System Template for Psychiatric/Psychological Assessment and Initial Inpatient Care- use the guidelines below for accessing the system template to document care in the Individual Progress Note and Crisis Progress Note.

Beginning Monday, December 17, 2018, BHD is implementing new standards for documenting psychiatric/psychological assessment and initial inpatient care. The current IP Psychological/Psychiatric Assessment Form will no longer be available and will be a read only document in Chart View to review assessments completed prior to December 17th. The new system template will not be a stand-alone form, but instead will be within the narrative portion of the Individual Progress Note and Crisis Progress Note Forms.
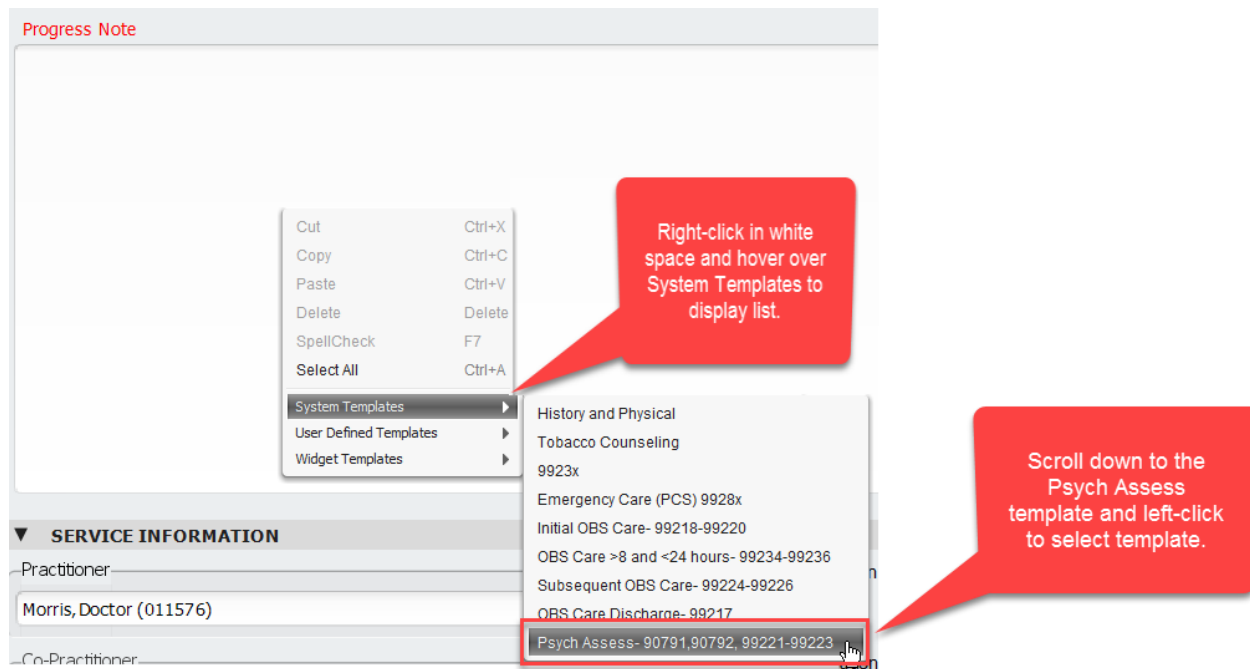
Important Change- a new note type (Psychiatric/Psychological Assessment) will be used in conjunction with the new template. Select this Note Type when using the new system template to document a psychiatric or psychological assessment.

To access the new template, right-click in the scrolling free-text field in either note and hover your mouse over **System Templates** to display a list of the new templates. To select the new template, scroll down to the bottom of the list and left-click on the **Psych Assess- 90791, 90792, 99221-99223** template.

The template opens in the scrolling-text box field.

Sample System Template

Scroll through the entire template inserting information as needed (all required fields need to be completed for accurate billing documentation) and deleting information as appropriate. See the following pages for a template example and comprehensive 'how to use' instructions.

Psychiatric/Psychological Assessment and Initial Inpatient Care Template - (90791, 90792 and 99221-99223)

Psych Assessment

Chief Complaint (CC) [**Required**]:

History of Presenting Illness (HPI) [**Required** - Include recent history of Violence to Self and Others, Trauma, and Loss of Control with AODA]:

Past Psych Hx (**Required** w/Violence, Trauma and Loss of Control history -if not in HPI):

Developmental History (*Required on CAIS*):

Allergies (Edit apropos): Reviewed in the EHR / Reviewed with patient

Past Medical and Current Status (PMHx) [*Required for 90792 and 99221-99223*]:

Medications at Admission (Edit apropos) [*Required for 90792 and 99221-99223*]: Reviewed PCS orders / Reviewed home mediation list provided by Case Management or CSP / Reviewed by patient report

Family History (Psych and pertinent Med) [**Required**]:

Social History and Initial D/C Housing Plan [**Required**]:

Review of Systems (ROS) [*Required for 99221-99223*]:

Exam (Psychiatry Specialty Exam) [**Required** - Estimate intellectual functioning, memory functioning and orientation required for CMS COPs – Detailed or Comprehensive Exam bullets for Billing]:

Inventory of Assets – List two Patient Inherent Strengths [**Required for CMS COPs**]:

Medical Decision Making (MDM)/Plan of Treatment [**Required including a ICD/DSM V Diagnosis and formulation**]:

Estimated Length of Stay (ELOS) [**Required**]:

Estimated Initial Discharge Level of Care [**Required**]:

Legal – PC Hearing Recommendations thus far [*Required on involuntary care cases*]:

Psych Assessment and Initial Hospital Day

Instructions for Use (90791 and 90792, 99221-99213):

This is intended to be a general template for any psychiatric assessment. It is designed to be able to be used by multiple disciplines (MD, PhD, LCSW/MSW, etc) and at multiple levels of care. That said, it is heavy on the Inpatient Requirements. Finally, in practical use the practitioner is free, within the scope of their license and privileges, to adjust the template to the particular encounter context and patient you're treating.

The template lists the required headings and content of psychiatric/psychological assessment (Psych Assessment) [90791 and 90792] and evaluation and management (E&M) initial hospital day [99221-99223] billing; there are some items that are not required for the 90791 but all others, and there are some items required for the Child and Adolescent Inpatient Service (CAIS). In addition, there are some items that are required based upon 42 CFR 482.60 - Special provisions applying to psychiatric hospitals, the so-called Center for Medicare/Medicaid Services Conditions of Participation (CMS COPs). Further, you can or may need to edit or modify some of the lines to the level of the code your billing.

CC Line:

Chief Complaint (required): "

> Place our cursor right of the ", type in the Chief Complaint."

> e.g., Chief Complaint (required): "I want to go home..."

HPI Line:

History of Presenting Illness (HPI) [**Required** - Include recent history of Violence to Self and Others, Trauma, and Loss of Control with AODA]:

All levels of Psych Assessment require an Extended, 4+ History of Present Illness, meaning you need to assess and document 4 symptoms or aspects of the illness (OPQRST dimensions of symptom - Onset of the event, provocation or palliation, quality of the symptom/complaint, region/radiation, severity, and time course).

Also address recent and historical violence to self and others, trauma and loss of control with substances. Please note that synthesis of historical records, and patient or collateral sources are able to be used. Further, note if unable to elicit from an uncooperative, unwilling or non-verbal/impaired patient to signify the attempt to assess.

Past Psych Hx (**Required** w/Violence, Trauma and Loss of Control history -if not in HPI):

Please list the relevant past psychiatric history. While the E&M Codes allow either one or two + of Past History, Social History and Family History, the CMS COPs for require all three.

In addition, please include any additional risk information related to violence to self/other, trauma and loss of control with substances – note you are not required to enter the data in both locations, but must include both recent and historical data, you can choose where you document it. Please include as appropriate: age of onset of self-injury and/or first suicide attempts, any precipitating factors related to onset of self-injury and/or suicide attempts, preferred method(s) of self-injury and/or suicide attempts. Please ensure clearly demarking attempts that could have been lethal.

Developmental History (*Required on CAIS*):

Please note developmental history including appropriate milestones, dynamics and pregnancy/labor and delivery issues. This is required on all CAIS admissions; please include assessment of the following items: current school, highest grade/educational level attained, history of special education or IEP services, history of learning problems, and current employment status.

Moreover, its use should be considered on appropriate adult cases when patients are under the age of 21 and/or their clinical syndrome has its origin in development or childhood.

Allergies (Edit apropos): Reviewed in the EHR / Reviewed with patient

A review of allergies is required. Two options are proffered for you, please document the one you complete and delete the other. In addition, if you wish you can enter the description you feel best fits for the service you provide.

Past Medical and Current Status (PMHx) [*Required for 90792 and 99221-99223*]:

Past Medical History and Current Status are required for 90792 and 99221-99223. It is optional for 90791. You should list relevant medical illness and per the CMS COPs address their current status. For example, Hypertension on medical management, Diabetes Mellitus type 2 on diet and exercise with HgbA1c of 7 at last primary care appointment. COPD on CPAP with variable compliance by patient.

Medications at Admission (Edit apropos) [*Required for 90792 and 99221-99223*]: Reviewed PCS orders / Reviewed home mediation list provided by Case Management or CSP / Reviewed by patient report

A review of the patient's medications is required for 90792 and 99221-99223. It is optional for non-medical discipline evaluations such as those billed under 90791. Three options are proffered for you. Please document the scope of review that you complete, even if multiple of the options listed in the template. In addition, you may choose to use a different description and delete the template and document your description.

Family History (Psych and pertinent Med) [**Required**]:

99221 requires two of three history areas and 99222-99223 require three areas. However 90791, 90792 and the CMS COPs require all three.

Social History and Initial D/C Housing Plan [**Required**]:

Similar to the Family History for Social History, 99221 requires two of three history areas and 99222-99223 require three areas. However 90791, 90792 and the CMS COPs require all three.

In addition, per the CMS COPs and Wisconsin DHS 51 you are required to comment on housing plan. For example, patient will return to their apartment; or, patient is appropriate to return to a room and board, however likely will need to find a new location.

ROS Line:

Review of Systems (ROS) [*Required for 99221-99223*]:

Per the 1995/1997 CMS E&M Documentation requirements there are 14 systems: Constitutional, HEENT (Eyes, Ears, Nose, Mouth and Throat), Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary (skin and/or breast), Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic and Allergic/Immunologic.

To meet the CPT requirements a 99221 requires 2 systems, 99222 and 99223 requires 10 or more systems reviewed. 90791, 90792 have no clear minimum ROS requirement other than that you have completed some review of systems. Moreover the CMS COPs for IMDs do not list any additional guidance other than a review that is clinically appropriate to the patient.

Psychiatry Specialty Exam Line:

Exam (Psychiatry Specialty Exam) [**Required** - Estimate intellectual functioning, memory functioning and orientation required for CMS COPs – Detailed or Comprehensive Exam bullets for Billing]:

We use the CMS 1997 E&M Psychiatry Specialty Exam to document most billing encounters. Please keep in mind that the exam requirements for billing are starting point for documenting and in general for good clinical care and medico-legal requirements you will exceed these minimums. However, you likely will not be able to up-code on the bases of a more thorough exam alone. Also, please note that the CMS 1997 E&M Psychiatry Specialty Exam is not just a Mental Status Exam (MSE), there are three areas including Musculoskeletal, Constitutional and Psychiatric.

For 99221 you need to assess and document nine or more elements and for both 99222 and 99223 you need one element from musculoskeletal and all elements in both the constitutional and psychiatric domains. For both 90791 and 90792 you also need a comprehensive examination like the 99222/3 exam.

Under the CMS COPs you are required to document exam findings for Estimate of Intellectual Functioning, Memory (including immediate, recent and remote) and orientation.

Finally, the E&M Billing/regulatory requirements are a minimum and adequate documentation of exam for risk mitigation is often more important.

Inventory of Assets Line:

Inventory of Assets – List two Patient Inherent Strengths [**Required for CMS COPs**]:

You are required on hospital admissions to list the patient strengths. These need to be inherent and or intrinsic to the patient. External resources such as family, housing, insurance, job or others are not inherent or

intrinsic. Examples such as sense of humor, intelligence, perseverance, or capacity to modulate affect. These all ought to be items that can be leveraged during treatment planning to help the patient.

Medical Decision Making (MDM)/Plan of Treatment [**Required including a ICD/DSM V Diagnosis and formulation**]:

Medical Decision Making (MDM) is more than just listing a diagnosis (which you are required to list in alpha form; e.g., Bipolar, Manic with Psychotic Features); it is more than an assessment and plan. It is the integrative cognitive work of weighing the data and information, determining what additional data and work up are needed, weighing relative risk of types of evaluations and treatment and determining the collective complexity.

Per CMS the levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The specifics of Medical Decision Making will be reviewed in detail at a future Billing and Coding Update.

- 99221 is for problems of low severity with low complexity MDM.
- 99222 is for problems of moderate severity with moderate complexity MDM.
- 99223 is for problems of high severity high complexity MDM.

Under the CMS Conditions of Participation, hospital admissions at psychiatric hospitals require an integrative assessment of the History and Physical exam (if completed by a staff other than the psychiatrist), social work assessment and nursing assessment, in addition to the information in the psychiatrist's psychiatric assessment.

The American Psychiatric Association (APA) Practice Guideline for the Psychiatric Evaluation of Adults, Second Edition notes that assessments include: a clinical formulation, cultural formulation, risk assessment for harm to self/others, diagnostic formulation including relevant personality/character components, initial treatment plan, legal and administrative issues and systems issues. Each of these sub-categories should be flushed out in the context of the specific patient, which is to say some cases will require complex multi-category formulation, while others may necessarily be rather narrow.

Estimated Length of Stay (ELOS) [**Required**]:

All insurance companies require some initial estimate of the period needed for inpatient. Consider the following ranges as pragmatic anchors in documenting this item: 72 hours or less, three to five days, five to seven days, seven to ten days, two weeks, likely more than two weeks. Please note the estimated length of stay should be based in historical response to treatment, need for legal/commitment processing and reasonable response to treatment modalities. Thus, this estimate should logically flow from the rest of the documented psych assessment.

Estimated Initial Discharge Level of Care [**Required**]:

Please make some integrative assessment of likely needed care post hospital. Options to consider include, Community Support Program, Partial Hospital Program, Intensive Outpatient Treatment, Comprehensive Community Services, Case/Care Management, etc. Please note need for mental health, AODA or dual capable treatment.

Legal – Legal Status and PC Hearing Recommendations thus far for new involuntary cases [**Required per CMS COPs**]:

Please note the legal status voluntary, guardianship, etc. In cases of involuntary care, your HPI should note the specific legal hold (Three Party Petition, Emergency Detention, Treatment Director Affidavit, or Post Protectory Conversion, etc.), here please note your initial estimate for how a commitment hold should be resolved, for example; pre-probable cause settlement, final commitment, will proceed to probable cause and consider settlement based upon further response to treatment, etc.